

## **Maryland Department of Health and Mental Hygiene**

### **CONCEPT PAPER**

#### **Integrating Care to Meet the Needs of Medicare-Medicaid Dual Eligible Beneficiaries in Maryland**

##### **I. Opportunity for Innovation in Care Design**

Medicare-Medicaid dual eligible beneficiaries in Maryland are a high-need, high-cost population. Many face complex medical, social and/or behavioral challenges that demand extraordinary care coordination efforts to generate favorable outcomes. Dual eligible beneficiaries cost each program much more per capita than do other beneficiaries, often consuming services that could be avoided with the right early and sustained interventions. Designing a model to improve their care, their health outcomes and their quality of life, while also containing spending at both the federal and state levels, requires the alignment of both programs to avoid perverse incentives that lead to needless costs and cost shifting.

To date, Maryland has exempted dual eligibles from its Medicaid managed care program, HealthChoice. Recognizing that close alignment with the State's all payer model is beneficial for the dually eligible population, the Maryland Department of Health and Mental Hygiene (DHMH) proposes a Medicare-Medicaid Duals Accountable Care Organization (D-ACO) model of value-driven care coordination to serve Medicare-Medicaid dual eligible beneficiaries. The model is innovative, though the key elements are built upon recognized models - Patient-Centered Medical Home (PCMH) and the Medicare Shared Savings Program (MSSP) Accountable Care Organization (ACO). The model is a form of value-based purchasing, pursuing the benefits of provider accountability for cost and quality while emphasizing the centrality of primary care. This measure is fundamental to reducing the rate of growth of health spending in Maryland.

The initiative will be implemented in 2019, initially in certain geographies – Baltimore City, Baltimore County, Montgomery County, and Prince George's County. These areas are home to approximately 52,000 Marylanders who receive both Medicare and full Medicaid benefits ("full dual eligible beneficiaries") and who are not intellectually or developmentally disabled (I/DD). This initiative targets the estimated 47,000 persons within this group who receive Medicare benefits through original fee-for-service Medicare. The rest of this group are enrolled in Medicare Advantage (MA) plans and will not be impacted by the model unless any disenroll from MA and return to original Medicare.

The proposed model will integrate seamlessly with the broadening of the global budget concept beyond hospital expenditures to encompass total cost of care (TCOC), per beneficiary, for

Medicare outlays, and for dual eligibles, both the Medicare and Medicaid outlays. The D-ACO Model will incorporate a combined TCOC of Medicare and Medicaid for dual eligibles and the calculation methodologies will be aligned.

The innovation described in this document will institute powerful incentives for controlling the total cost of both Medicare and Medicaid for the affected population. Approximately \$2 billion of combined annual program spending, historically all fee-for-service with incomplete coordination, will come under the new model's control mechanisms. The D-ACO Model will be one linchpin to the success of the All-Payer Model.

The cornerstone of the care delivery redesign within the D-ACO is the Person-Centered Health Home (PCHH). The PCHH incorporates elements of the Maryland Comprehensive Primary Care Model program being developed by DHMH and will include similar features to Maryland's Chronic Health Home program, which was established under Section 2703 of the Affordable Care Act, and serves a small segment of the population with diagnoses of serious persistent mental illness, serious emotional disturbance, and opioid substance use disorders.

The person-centered care redesign will be bolstered with payment innovations to incentivize the investments and behaviors needed to produce quality and cost-effective outcomes.

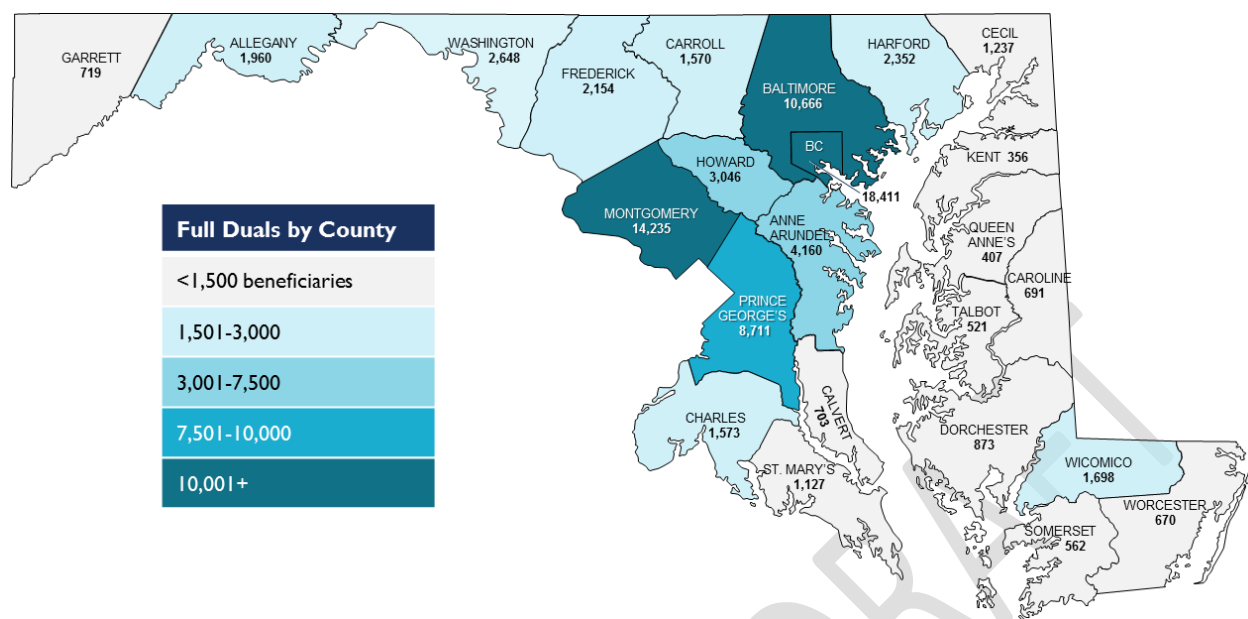
The remainder of this paper outlines key policy and operational components for a program designed to address the health and social needs of dual eligible beneficiaries in Maryland. First, we present some information on the characteristics of Maryland's dual eligible beneficiaries.

## **II. Overview of Dual Eligible Beneficiaries in Maryland**

As of FY 2016, 81,362 full dual eligible beneficiaries, excluding the intellectually or developmentally disabled (I/DD), reside in Maryland. The four jurisdictions in which the proposed D-ACO Model will operate are home to 64% of this population: Baltimore City (23%), Baltimore County (13%), Montgomery County (17.5%), and Prince George's County (10.7%).

In CY 2012, 62% of full-benefit dual eligible beneficiaries were female and 55% were 65 and older. However, the majority (57%) of male dual eligible beneficiaries were under the age of 65 and the majority (62%) of female dual eligible beneficiaries were 65 and older.

More than half (55%) of newly enrolled full-benefit dual eligible beneficiaries in CY 2012 were under the age of 65, while 56% of those continuously enrolled (meaning there was no break in their dual eligibility benefit determination in CY 2012) were 65 and older. More than two-thirds (70%) of CY 2012 full-benefit dual eligible beneficiaries were eligible for Medicare before obtaining Medicaid coverage.



Total Medicaid expenditures for full-benefit dual-eligible beneficiaries rose 10%, from \$1.48 billion in CY 2010 to \$1.62 billion in CY 2012. Medicare expenditures grew at a slower rate of 4% during this period. On average, Medicaid paid slightly more per person per year than did Medicare.

Individuals who use long-term services and supports (LTSS) through either home- and community-based services (HCBS) or extended nursing facility stays are among the costliest dual eligible beneficiaries. In CY 2012, HCBS users' combined Medicaid and Medicare spending was almost \$50,000 per person; while for those residing in nursing facilities the cost exceeded \$100,000. Other dual eligibles who reside in the community setting and are not dependent on HCBS, referred to as community dwelling, cost just under \$19,000 per person per year.

Approximately 10% of full dual eligible beneficiaries statewide are currently enrolled in Medicare Advantage plans and will not be affected by the D-ACO Model.

### III. D-ACO Program Theory of Change

Currently, Medicare-Medicaid dual eligible beneficiaries in Maryland are served in a largely uncoordinated fee-for-service delivery system. As a high-cost, high-need population, Medicare-Medicaid dual eligible beneficiaries' needs span beyond primary, acute, and chronic care, often including behavioral health, long-term services and supports, and other social supports. However, the services intended to meet these needs are not delivered in a coordinated manner; in fact, many assessments, care planning functions, and other activities overlap or are duplicated to various degrees between Medicaid and Medicare. The present system creates a multitude of care management initiatives, processes and programs, none of which addresses the full spectrum of Medicare-Medicaid dual eligible beneficiaries' needs longitudinally.

The D-ACO Model is designed to create a holistic, sustained care coordination intervention that bridges the divide between social determinants, long-term care, behavioral health, and physical health by vesting the care coordination function in a single entity. The D-ACO Model will financially align Medicare and Medicaid services. It further develops a unified and comprehensive assessment inclusive of common elements to address behavioral health, social services, and long-term care, creating accountability and responsibility for that spend, and linking its delivery to the delivery of traditional health care services in a care coordination program.

The D-ACO model transforms care delivery for dual eligibles by triangulating each beneficiary with the care coordination and management supports and their clinical and social needs. While this concept can be associated with fragmented care, the D-ACO model avoids such potential by adding the following elements: collaboration across specialties via medical homes, interdisciplinary care teams, and care management that is integrated and delivered at the clinical setting. All of these elements are scientifically validated mechanisms to ensure coordinated care, improved health outcomes, and reductions in hospital admissions and emergency department visits.

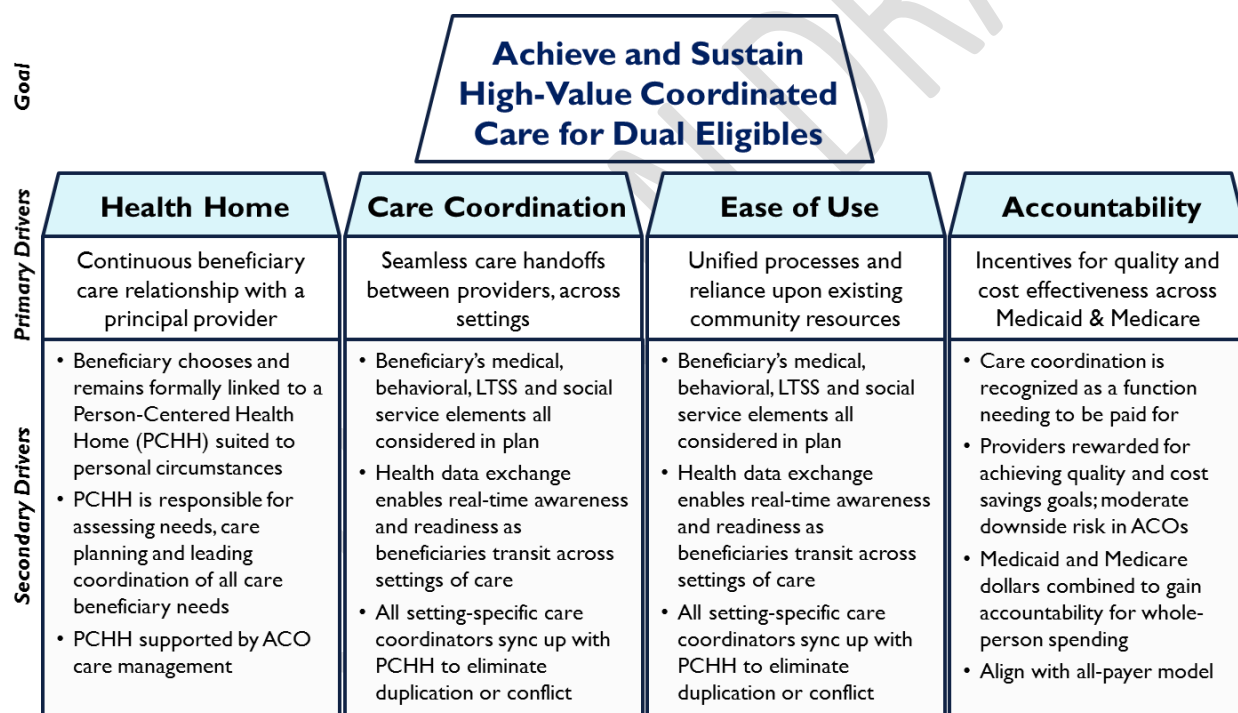
The D-ACO model offered here introduces care coordination along with incentives for providers to meet the needs of dual eligible beneficiaries while promoting efficiency and quality:

<b>Current FFS System</b>	<b>D-ACO Model</b>
Many beneficiaries lack a go-to provider	Beneficiary-designated provider who is care coordination lead
Discontinuity in care, especially across physical, behavioral, LTSS and social domains	Seamless coordination across health care settings and spanning to include social supports
Provider incentives reward volume and intensity of services	D-ACO materially accountable for total cost of care plus quality
Repetition of assessments, services, testing, procedures	Care coordination tools enable access to data -- assessments, tests, medical encounters Promote standardized processes and assessments
Lack of provider capacity to coordinate care	Incentivize providers and offer resources to coordinate care

Thanks to the contributions of a stakeholder work group that has convened monthly since January 2016, the D-ACO model follows guiding principles that emanate from a goal of **achieving and sustaining high-value coordinated care for dual eligible beneficiaries.**

As depicted in the driver diagram below, the D-ACO program will:

- leverage the person-centered health home concept to ensure each beneficiary is connected and engaged to a designated provider,
- implement new care coordination techniques in which key providers work across disciplines to address the beneficiary's needs, and
- offer unified processes to reduce duplicative assessments, care plans and diagnostic tests, and enforce accountability through carefully measuring both quality of care and the total cost of care.



For beneficiaries, the model will improve beneficiary engagement, the experience of care, improve access to care, improve health outcomes, and raise quality of life. The model will align financial incentives across Medicare and Medicaid to reward higher quality of care and support providers via health information exchanges, analytical tools, and administrative aids.

The D-ACO model is designed to be practical to mesh with other population health efforts that providers are already pursuing. The proposed models are designed to draw upon existing

community resources that beneficiaries already depend upon. Design elements that will serve to achieve the goal of achieving sustained, high-value, coordinated care include:

- A network of person-centered health homes (PCHHs) capable of handling the clinical needs – including physical, behavioral, long term care and social supports – of dual eligible beneficiaries.
- Data infrastructure to inform D-ACOs and PCHHs of clinical events and data analytics and exchange capabilities driven by D-ACOs to inform PCHHs at the practice level about their performance and targeted approaches to engaging with and addressing the needs of beneficiaries.
- Individualized interdisciplinary care teams (ICTs) formed by a selected group of clinicians, social support resources, and care managers to address the needs of the beneficiary and to guide the care planning process.
- Care management and care coordination roles and functions that are carried out by the D-ACO and PCHH, respectively.

The design will ensure that clinicians can also qualify for Advanced Alternative Payment Models (Advanced APMs) under MACRA's Quality Payment Program.

These concepts are detailed in the following sections.

#### **IV. D-ACO Care Model Design**

This section presents the concept of the D-ACO and the PCHH and then speaks to the elements of care redesign. Maryland DHMH proposes an accountable care organization model design, titled a Medicare-Medicaid Duals ACO or D-ACO, for an initial set of counties – selected for population density and availability of health systems willing to engage. The D-ACO model will employ a shared savings and care coordination services payment system built upon rigorous care coordination model including support from and participation in state-operated data sharing programs.

Key characteristics of the D-ACO:

- Have a broad network of PCHH and specialty providers representing all services dual eligible beneficiaries use – physical health, behavioral health, LTSS – that are traditionally covered Medicare and Medicaid benefits, plus ways to connect beneficiaries to social supports and community services.
- Embrace and incorporate the PCHH model of care by performing care management and quality improvement activities, and measuring their effects.
- Support participating clinical practices to perform optimally, both by aiding in the process of care coordination and by supplying data and analytics – to both clinically

manage their patient panel and coordinate their care as well as to indicate their performance on defined process and outcome metrics as compared to their peers.

- Ensure that providers representing services utilized by dual eligible beneficiaries – including behavioral health and long-term care services – are leveraged in care delivery policy-making and program operations, such as by reviewing and approving policies, overseeing case management functions, and engaging in discussions on specific beneficiary case examples.
- Accept a minimum designation of at least 2,500 full dual beneficiaries.

In the first two years of the program, D-ACOs will have the opportunity to earn rewards for producing savings and quality gains for the beneficiaries they serve, and will be expected by the third year to take meaningful risk for financial losses that may arise.

Embedded in the D-ACO is an integrated provider network with features similar to the ACOs in the MSSP but exhibiting a number of crucial differences described further herein. As part of the integrated provider network, D-ACOs will be required to enter into shared savings participation contracts with PCHHs, who will be central to beneficiaries' care delivery and care coordination – encompassing physical, behavioral, LTSS and social supports.

D-ACOs will operate in regions with high concentrations of dual eligible beneficiaries and where conditions are favorable for D-ACOs to form – namely areas that have the providers willing to form a D-ACO and the beneficiary base to make it worthwhile from a business standpoint. Initially, the D-ACO initiative will focus on Baltimore City, Baltimore County, Montgomery County, and Prince George's County – where more than three-fifths of all full dual eligible beneficiaries reside. The counties the initiative focuses on could be expanded upon based on the degree of provider engagement and success of the initiative. For instance, adding just the two neighboring counties of Anne Arundel and Howard would bring nearly 10 percent more of the population into the program.

D-ACOs may define their own service areas within the defined regions, provided those areas are contiguous and non-discriminatory. More than one D-ACO will be offered in all areas, to ensure competition between D-ACOs, to enable clinicians associated with competing health systems to engage, and to ensure that most beneficiaries will continue to have access to current providers. However, DHMH expects to limit the total number of D-ACOs, in the interest of limiting the State's administrative burden.

The D-ACO model will leverage existing ACOs that have formed to serve Medicare fee-for-service beneficiaries generally. Based on CY 2012 data on all full-benefit Medicare-Medicaid dual eligible beneficiaries, most (70%) dual eligible beneficiaries were eligible for Medicare before obtaining Medicaid coverage. A large percent of current full Medicare-Medicaid dual eligible beneficiaries eligible for the D-ACO model are likely engaged in Medicare ACOs. Twenty-

six MSSP ACOs have formed in Maryland and some of them are interested in becoming D-ACOs, too.<sup>1</sup> New ACOs may form just to serve dual eligible beneficiaries; these D-ACOs will not be required to participate in MSSP to qualify as D-ACOs.

It will be to the advantage of the dual eligible beneficiaries and their families, given their diverse health and social concerns, for D-ACOs to differ in some ways CMS's Medicare ACO definition. It is especially important to give prominence to LTSS and behavioral care providers for the large numbers of dual eligible beneficiaries in need of those services. To qualify to serve dual eligible beneficiaries or to become a D-ACO, these entities will also have to demonstrate an understanding of dual eligible beneficiaries and their physical, behavioral, social, and long-term services and support needs.

#### **a. D-ACO Shared Savings Network Standards**

The D-ACO model has been selected, as opposed to either a closed-network, capitated model or a managed fee-for-service model because of a key feature that is exclusive to an ACO model: access to coordination and care management for a fully integrated network of providers without any limitation on the beneficiary's choice of providers.

D-ACOs must furnish a network of providers with agreements for all services covered by Medicare Parts A and B, and by Maryland's Medicaid program, including all long-term services and supports for the non-I/DD population. D-ACOs will be required to offer broad networks to include a diverse and large number of PCHHs and specialists. D-ACOs will also be responsible for coordinating services when beneficiaries access care outside of the participating provider network.

Beneficiaries will either designate a D-ACO on their own or the State will do that for them, as detailed in Section VI below. The beneficiary designation process will be based on an intelligent methodology whereby beneficiaries will be connected to D-ACOs that offers the most suitable network for each individual based on historical utilization patterns (found in claims data) and other factors. It will be in the best interest of the D-ACO to offer a network that is broad enough so that beneficiaries, during the designation process, have access to a PCHH and complete network of participating specialists with whom they have a treatment history and geographic proximity.

#### **b. Person-Centered Health Home**

The cornerstone of the model is a Person-Centered Health Home (PCHH) that will serve as the beneficiary's designated provider and constant care coordination resource.<sup>2</sup>

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<sup>1</sup> Based on CMS's 2016 Medicare Shared Savings Program (MSSP) ACO programs available at: <https://www.cms.gov/medicare/medicare-fee-for-service-payment/sharedsavingsprogram/acos-in-your-state.html>.



The goal of the PCHH is to recognize the individual needs of the beneficiary and deliver integration of physical health, behavioral health, long-term services and supports, and social supports. The D-ACOs will support the PCHH with real-time data, beneficiary needs assessments, and guidance on where best to target resources for the greatest impact.

Owing to their complex array of needs, not all dual eligible beneficiaries use traditional primary care physicians as their principal source of care. Many dual eligible beneficiaries rely upon multiple other types of clinicians. Therefore, PCHHs will not be limited to traditional primary care providers; a behavioral health, specialty medical, or long-term care provider that serves as the main source of care for a beneficiary may serve as the PCHH as well. This is a key distinction between the D-ACO program and other programs that use primary care medical homes (PCMHs) that emphasize a relationship with a traditional primary care provider and typically focus on medical care over other needs.

DHMH expects the PCHHs to meet standards of accreditation such as those applied to Primary Care Medical Homes set by national accreditation bodies, though some deviations may be warranted.<sup>3</sup> In Maryland today, 1,248 practices are recognized as accredited PCMH sites by the National Committee on Quality Assurance. Many of these sites were part of Maryland's Multi-Payer Patient Centered Medical Home Pilot and CareFirst Blue Cross Blue Shield's PCMH Strategy. The majority of these practices (82% or 982 practice sites) attained Level III recognition, the highest level of accreditation.

Person Centered Homes that will be created under the Maryland Comprehensive Primary Care Model could serve as PCHHs within D-ACOs, as long as they meet the requirements applicable to dual eligibles. While beneficiaries accessing services through existing programs will not be removed from accessing these benefits, policies will be further developed to ensure providers are unable to expense the already covered service or care coordination and management activities to the D-ACO model.

The D-ACO is the entity that will hold a contract with CMS and DHMH. While PCHHs and all other providers will continue to receive fee-for-service payments, D-ACOs will also be required to compensate the PCHH entity for care coordination services and to share any awards received for achieving savings and quality goals with the PCHH and other participating providers. The model allows for variation in the level of financial and administrative support the D-ACO gives to each PCHH based on each practice's capacity for delivering care coordination functions. In

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<sup>2</sup> The PCHHs envisioned in this model are distinct from Maryland's chronic health homes authorized by Section 2703 of the Affordable Care Act. The latter will be eligible to apply to become PCHHs, though.

<sup>3</sup> The Patient Centered Medical Home (PCMH) concept is managed by the Agency for Healthcare Research and Quality, at a Federal level. The National Committee on Quality Assurance (NCQA) and The Joint Commission are national, non-profit, governing boards that develop, maintain, and administer PCMHs and provides accreditations and guidance on standards.

their proposals, D-ACOs will describe their methods for paying PCHHs for care coordination and for sharing savings/losses with PCHHs and all other participating providers.

The risk and rewards section below (Section VII) details how rewards will be shared and penalties will be placed to D-ACOs. D-ACOs will be required to flow some of their income to PCHHs based on the extent of care coordination duties that is delegated to the PCHH practice.

### **c. Care Management and Coordination**

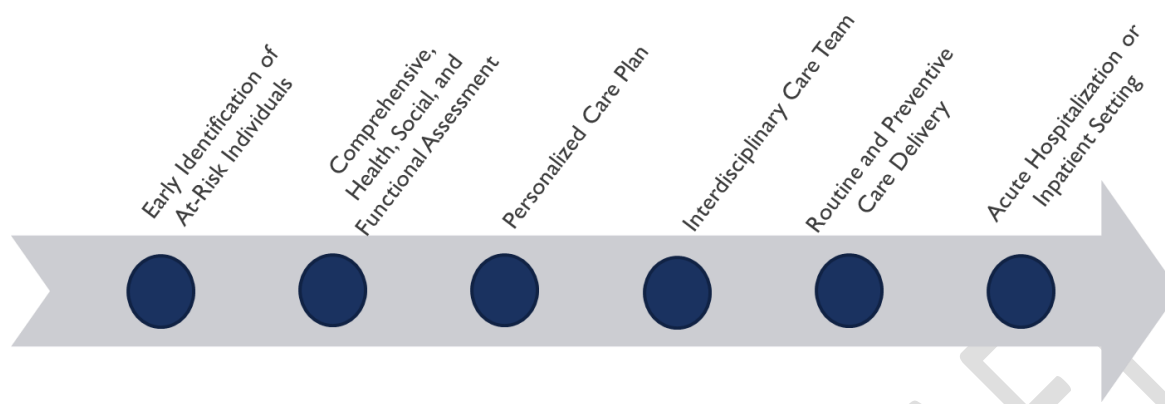
For the D-ACO model, DHMH and stakeholders have delineated the roles and definitions of care management and care coordination as follows:

- Care Management is a process designed to assist PCHHs and their support systems in managing their medical, social, and behavioral health conditions more efficiently and effectively and as possible achieve self-direction and self-management.
- Care Coordination is the tactical and operational organization of beneficiaries' care activities; this includes family caregivers. Coordination will address the social determinants of health and facilitate the delivery of appropriate health care, long-term care, and supportive social services.

To this end, the D-ACO model generally assumes the care management function to be carried out by the D-ACO and the care coordination responsibilities to be performed at the PCHH level. However, variation will be permitted, provided that the D-ACO is answerable for meeting the demands of the contract with Medicaid and Medicare. The exact division of responsibilities between D-ACO and PCHH will be flexible so that each D-ACO will determine the assignments in partnership with its PCHHs.

The care management and care coordination process will proceed according to a structured timeline from beneficiary designation through ongoing support. The next section describes the interactions between the beneficiary, the D-ACO, and the PCHH along the health care continuum.

The proposed diagram and process serves as an example of how the care continuum could be designed to avoid negative and unintended health outcomes, which are also addressed. We understand that in real world situations, the process for any individual may have to start at any point along the continuum.



- 1) Early identification of individuals at risk for physical health and social needs that are often co-morbid to behavioral health deterioration, substance abuse disorders, and the onset of long-term services and support needs
  - i) D-ACOs will be furnished with Medicaid and Medicare claims data for each beneficiary they are designated. D-ACOs operate tools that enable data exchange via CRISP<sup>4</sup> and population health analysis to categorize beneficiaries as low, moderate, or high-risk for the purposes of care coordination interventions.
  - ii) PCHHs receive regularly updated reports with a list of their highest risk patient panel to engage with and ensure access to clinical and social services required to close gaps in care.
- 2) Comprehensive medical, functional and social assessments
  - i) Dual eligible beneficiaries in Maryland are currently accessing assessments through various Medicaid state plan and waiver programs, programs specific to Medicare, and facility-specific assessments. Many of these assessments are disjointed, producing redundancy in assessments and sometimes in the creation of multiple care plans for one individual when they span across Medicare and Medicaid. Existing assessments and care plans will be evaluated to identify how to best incorporate within the care management and coordination efforts of the D-ACO model.
  - ii) It is the intent of the D-ACO program to enable access to information on assessments conducted between the Medicare and Medicaid programs and to develop a unified structure whereby redundant data elements are removed and assessments are integrated and simplified.

<sup>4</sup> CRISP (Chesapeake Regional Information System for our Patients) is Maryland's health information exchange.

- iii) While additional assessments will need to be conducted for specific events and care plans will need to be updated, the intent is avoid duplication and repetition and give both the caregiver and the beneficiary a much smoother experience of care.
- iv) The overall assessments in the D-ACO initiative will include several components, and can incorporate elements already dealt with in long-term care needs assessments such as MDS and interRAI:
  - (1) Clinical needs including long-term care and behavioral needs
  - (2) Mobility including physical access within the beneficiary's home, to their health care settings and to social settings
  - (3) Social needs including housing, transportation, and nutrition
  - (4) Quality of life
- v) D-ACO care managers, at the outset of beneficiary assignment and through the beneficiary engagement process, collect and compile all available and relevant assessment information into a centralized assessment. The D-ACO is responsible for ensuring the assessments are updated annually and more often, based on specific health events.
- vi) PCHH care coordinators conduct face-to-face assessments based on prompts from the D-ACO and the beneficiary's clinical history and previous assessment results.

### 3) Personalized care plan

- i) PCHH care coordinator develops the care plan with the beneficiary and his/her family or caretaker. For higher risk D-ACO beneficiaries, the D-ACO will be required to complete the care plan and required updates in person with the beneficiary and caregivers/family. In addition, for higher risk beneficiaries, the care plan will be updated at least semi-annually. PCHHs will also routinely review the care plan with the beneficiary and family.
- ii) D-ACO care managers regularly access a centralized care plan and continually monitor the care plan to ensure the beneficiary has the means to achieve their goals.
- iii) D-ACO care managers will initiate a reassessment and update the care plan following beneficiary or caregiver request or the occurrence of any major health events, such as hospitalization, major surgery, admission to nursing facility, etc.

- iv) Many dual eligible beneficiaries are enrolled in HCBS and other LTSS programs to address their long-term care needs. As such, beneficiaries in the D-ACO model will likely be engaged in care, have an assessment, and may be working toward achieving goals they have formalized in care plans. These care management and care coordination efforts will continue and will be leveraged in the care planning process.

4) Interdisciplinary care team

- i) Each beneficiary surpassing a threshold indicative of a need for ongoing care coordination will be assigned an interdisciplinary team that consists of LTSS waiver program care coordinators, behavioral health specialists, and other need-specific providers.
- ii) Throughout the continuum of care, the ICT will be alerted of changes in the beneficiary's care and will huddle to assure the care plan and make clinical and coordination decisions. The ICT should be led by the PCHH care coordinator and will be responsible for engaging with the beneficiary and/or family representatives throughout the care delivery continuum.
- iii) D-ACO care managers are responsible for defining the individualized, interdisciplinary care team.
- iv) When there is a change in beneficiary status, the PCHH care coordinator convenes the ICT to review the clinical approach and coordinate services needed by the beneficiary. The PCHH makes warm hand-offs to specialists and other providers in the ICT to ensure engagement of the beneficiary and all providers in the care plan.

5) Routine and preventive care delivery

- i) D-ACO care managers continually identify wellness and health promotion activities that would be most useful to the beneficiary. D-ACOs also ensure that the beneficiary has received access to needed and appropriate services.
- ii) PCHH care coordinators facilitate scheduling of appointments, coordinate access to services, identify any new gaps in care, and connect beneficiaries to appropriate resources including those for home- and community-based services.

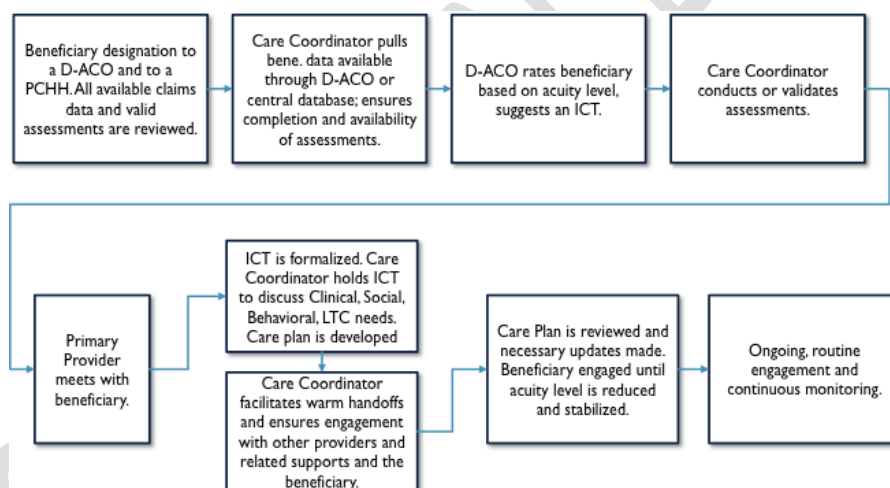
6) Acute hospitalization or inpatient setting

- i) D-ACO care managers receive alerts and notify PCHHs of triggering events in real time. The D-ACO care managers work with PCHH care coordinators and

hospital discharge planners to assure smooth transition from the inpatient setting to appropriate post-acute care.

- ii) PCHH care coordinators, in offices that are connected to CRISP's encounter notification system, receive the same real-time alert, if not the alert is delivered by the D-ACO. PCHH care coordinators convene the ICT, including the hospital or inpatient setting care coordinator, to review clinical needs and identify ways to stabilize and coordinate care for the beneficiary upon discharge.

Beneficiaries are supported by both the care coordinator and care manager to navigate the benefits and services that are accessible to them. The following workflow provides a sample process describing the interactions and hand-offs between the D-ACO, PCHH, specialists, and the beneficiary. Care coordinators are meant to serve as the vehicle to achieve decentralization of care coordination – triangulating the beneficiary, care managers and care coordinators at the care delivery or practice level, and the beneficiary's designated primary provider.



The D-ACO model assumes that transformation of care for dual eligible beneficiaries and improvements in the quality of care will occur thanks to an interdisciplinary care team approach, network cross-training, centralized member records, unified assessments and care plans, and a community-driven care model. These elements are detailed below.

#### d. Network Cross-Training

PCHHs and specialists will be expected to participate in cross-training programs run by D-ACOs. D-ACOs will address the topics such as the following:

- Behavioral health co-morbidities and tools to discern behavioral health needs
- Understanding connections between LTSS and other forms of care

- Identifying and connecting beneficiaries to community resources and social supports
- Review of assessments and instruments
- Role of the care plan and how it will serve as the guiding document in managing a beneficiary throughout their health care and social services continuum
- Metrics and outcomes
- Care coordination functions and responsibilities
- Using data from and reporting to CRISP
- Ways to use data analysis conducted by the D-ACO

D-ACOs will be responsible for communicating regularly to their providers to reinforce these concepts, such as by issuing a provider training manual and running periodic webinars.

**e. Centralized Member Record**

Given the various interactions each beneficiary may encounter, across payers and across settings, a critical aim of the D-ACO initiative is access to complete information about each beneficiary, ideally through a centralized member record. Beneficiaries may seek care at hospitals, physician offices or behavioral care clinics inside or outside a D-ACO's network. These providers may have linked electronic health records, but such linkages are not yet universal.

The D-ACO model will leverage existing CRISP infrastructure to offer the real-time notifications and alerts. The D-ACO model is based on the availability of an integrated technology system that will allow physicians, behavioral health specialists, LTSS providers, hospitals, and D-ACOs to deliver evidence-based care that is coordinated and personalized.

The goal is to ultimately provide meaningful information in the hands of the PCHH and the ICT to shape and positively impact the care of the beneficiary. The centralized member record element aims to embody the concept of the Patient-Centered Health Home concept by delivering the right information to the health home provider and various specialists and social support providers.

To address the lack of connectivity between settings and across payers, data infrastructure elements will address the following:

- Data exchange capabilities where all key providers can be notified in real time of critical events or concerns and all members of an ICT have access to the same information about the beneficiary
- Data analytics to assess whether beneficiaries are getting the right type of care at the right time and to predict future health concerns

- Data platforms that focus on retrospective insight as well as on measuring and analyzing the performance of direct interventions, utilizing predictive analytics, and housing, maintaining, and continually assessing care plans.

**f. Community-Driven Care Model**

Social factors play a key role in the effectiveness of health care and in the individual's ability to maintain health. The D-ACO model may address social needs including family and personal connections, transportation, housing, nutrition and employment options to achieve positive health outcomes. D-ACOs will be responsible for engaging with community resources in meaningful ways, to help meet beneficiaries' health-related needs.

**g. Consumer Protections**

As with any new approach to the provision of care, it will be vital to ensure that program participants are aware of the change, how it may affect their care and how they may seek support in the case of any issues or concerns after the model is implemented. D-ACOs will prioritize the inclusion of methods for consumer protections in the D-ACO model.

In addition to the extensive beneficiary counseling process described below, which is designed to maximize beneficiary choice and protect existing provider relationships, DHMH will develop a transition plan, focused on consumer education and outreach, to support D-ACO implementation.

The D-ACO model will also leverage existing processes available to beneficiaries, such as ombudsman programs, that are charged with giving a voice to consumers in addressing complaints or possible violations of rights. DHMH will also take into account the developments and recommendations of the newly-convened Consumer Standing Advisory Committee, which will consider consumer protections in light of new policies and initiatives.

**V. D-ACO Contracts**

A would-be D-ACO will need to submit an application that describes how the entity will operate and meet all the requirements detailed by DHMH (briefly listed above). D-ACOs must receive approval from DHMH for D-ACO designation. On a day-to-day basis, D-ACOs will look to DHMH for oversight, and CMS will empower DHMH with requisite delegation.

Established MSSP ACOs will be allowed to leverage their existing Medicare relationships and become D-ACOs through a streamlined process. Existing MSSP ACOs will need to augment capabilities, such as by adding LTSS providers to networks and by proving their ability to coordinate care across all Medicare and Medicaid covered services plus supportive social services. In addition, the beneficiary designation process and shared savings process for the two programs have numerous differences.



So, while MSSP ACOs will not be grandfathered into D-ACO status, they will have a streamlined pathway to selection based on their pre-existing governance structure and experience delivering care coordination services, reporting quality measures, and distributing savings. An MSSP ACO's participation as a D-ACO does not alter the MSSP model and the Medicare-only individuals it serves.

The D-ACO applicant will be required to show a number of participating providers sufficient to serve at least 2,500 beneficiaries. In addition, the D-ACO must demonstrate adequate participation from the full continuum of Medicare and Medicaid providers, including behavioral health and long-term care. The application will also require the submission of participation model contracts and a detailed shared savings/loss distribution methodology.

## **VI. Beneficiary Designation to PCHHs and D-ACOs**

### **a. Overview**

As with ACOs participating in the MSSP, a key element of the D-ACO program is the designation of Medicare-Medicaid beneficiaries to D-ACOs. The D-ACO program will employ a unique and innovative method of beneficiary designation that incorporates elements of the MSSP attribution process as well as the beneficiary counseling and support functions employed for the Medicaid MCO enrollment.

The D-ACO designation will serve as the basis of many key operational elements, including the initiation of care planning and care coordination, the calculation of financial and quality benchmarks, and the assessment of D-ACO quality and financial performance. However, unlike the attribution methodology used for MSSP ACOs, D-ACO designation will occur through a step-wise method that gives Medicare-Medicaid dual eligible beneficiaries affirmative choice in the selection of their D-ACO and PCHH. The proactive designation will allow for those D-ACO functions to take hold instantly, as opposed to some waiting for retroactive attribution.

The D-ACO designation process will entail outreach to the beneficiary before the effective date. There will be education and counseling to help beneficiaries make an affirmative choice about which PCHH and D-ACO to choose. These innovations will ensure that dual-eligible beneficiaries participating in the D-ACO program will be active participants in their own care planning and care management.

### **b. Beneficiary-targeted Materials**

D-ACOs and PCHHs will be prohibited from performing any marketing or educational activity to prospective D-ACO participants. D-ACOs and PCHHs will be required to distribute program education materials to current participants. DHMH will promulgate policies for materials that D-

ACOs and PCHHs may produce. All materials will be required to be submitted to DHMH or a designee for review and approval.

The educational materials will describe the location, hours, services, network, and other attributes of the program and will afford an opportunity for each D-ACO to highlight its unique approach. DHMH will approve these materials for use by the D-ACO and PCHH for current designees and DHMH will also use the same materials in the beneficiary outreach and counseling process.

**c. Beneficiary outreach, counseling, and PCHH/D-ACO election**

No later than 60 days prior to the beneficiary's effective date of proactive designation, DHMH or a designee will perform multiple initial outreach efforts by mail and/or telephone to prospective designees to notify them of their eligibility for the D-ACO program and the need to choose a D-ACO and PCHH. The beneficiary communication will emphasize the benefits of the D-ACO, including a summary of the additional care management services available while maintaining complete freedom of choice in existing Medicare and Medicaid providers.

The beneficiary counseling will start with the selection of a PCHH and will involve the discussion of the beneficiary's options based on his or her primary providers based on the results of a preliminary analysis of the proactive designation algorithm. This will allow the counseling team to provide PCHH and D-ACO options to the beneficiary based on his or her historical Medicare and Medicaid claims data, diagnostic history, and geographic location. If the beneficiary selects a PCHH that is exclusive to one D-ACO, the counseling is complete, but if the PCHH the beneficiary selects participates in two or more D-ACO's, the counseling continues to facilitate the selection of a D-ACO. DHMH or a designee will rely upon the educational materials provided by each D-ACO and PCHH following review and approval by DHMH.

Beneficiaries will be limited to their region. That means individuals in the northern region (Baltimore City and Baltimore County) will be precluded from electing a D-ACO that operates only in the southern region (Prince George's County and Montgomery County) and vice versa.

The beneficiary counseling will be culturally, linguistically, and disability competent and will build upon the experience and expertise of the local departments of social services to ensure that as many beneficiaries as possible are designated to a PCHH and D-ACO by election.

**d. Proactive Designation Methodology**

If a Medicare-Medicaid dual eligible beneficiary has not made an election of a PCHH and D-ACO, DHMH will employ a proactive designation methodology to designate the beneficiary to a D-ACO. The beneficiary will be notified of the designation no later than 30 days prior to the effective date of the designation. The D-ACO and PCHH will be allowed to initiate beneficiary

education and outreach efforts to initiate the care planning and care management process following the effective date of the designation.

The proactive designation methodology will follow a step-wise logic and will seek to reduce disruption to the beneficiary, build upon existing provider and care management relationships, and ensure the development of a successful relationship between the beneficiary and PCHH and D-ACO.

First, DHMH or a designee will determine whether the beneficiary is already attributed to an MSSP ACO. If so, DHMH will determine whether the MSSP ACO is also a D-ACO. If that is the case, the beneficiary will be designated to the same D-ACO where he or she has been attributed for the MSSP. If the beneficiary has not been attributed to an MSSP ACO, or the MSSP ACO is not a participating D-ACO, the beneficiary will then be attributed to a PCHH and D-ACO based on his or her utilization history. The designation will look at geo-location, services delivered at potential PCHHs, services delivered by providers within potential D-ACO networks, and the population/service focus of the D-ACO, if any. The designation will take into consideration diagnoses to ensure that beneficiaries with disabilities and special needs are designated to the PCHH best equipped to serve him or her. In addition, the designation will take into consideration the beneficiary's primary language and the linguistic competencies of the PCHH.

In the event that two or more D-ACOs are equally appropriate for a particular beneficiary, the beneficiary will be assigned to the D-ACO with the highest overall quality performance score (for the initial designation, which will occur prior to the calculation of any D-ACO quality scores, a D-ACO's benchmark quality score will be used). It is DHMH's intention to minimize the need to use the proactive designation methodology through the beneficiary outreach and counseling process described above.

#### **e. Changes in D-ACO and PCHH Designation**

Beneficiaries will have 30 days following the effective date of any designation – by election or by proactive designation – to make a change to a different D-ACO and/or PCHH within his or her region. After the 30-day period, a beneficiary will be able to change to a different D-ACO and/or PCHH on an annual basis or conditions warrant, such as a move to a different region.

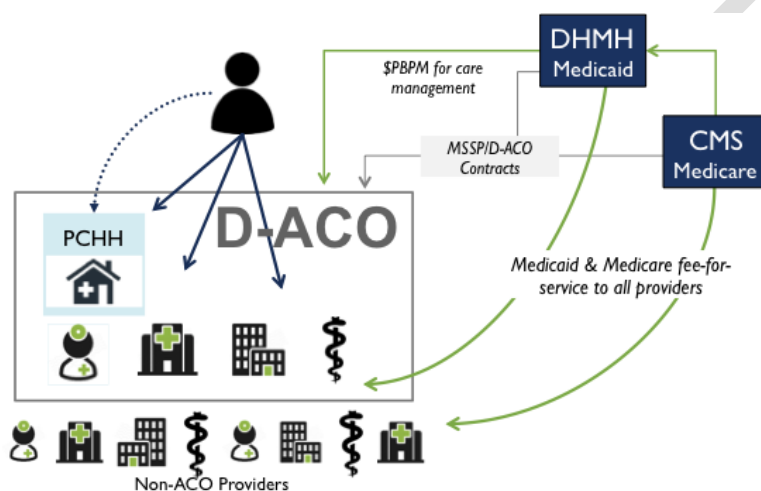
### **VII. Paying for Value**

The D-ACO model will include an innovative array of financing devices to alter the incentive structure in the Medicaid and Medicare fee-for-service system in Maryland to pay for value. The D-ACO model will include a shared savings and shared loss approach that is comparable to the one employed by the MSSP ACO program, Track 2.

The D-ACO model will also include a monthly care management fee. All providers will continue to receive regular Medicare and Medicaid fee-for-service payments for all services except for

the Medicare chronic care management (CCM) fee, which will be turned off for beneficiaries designated to a D-ACO, and invested in the D-ACO care management fee.

This combination of financing for up-front care management plus access to the long-term incentive of shared savings is a unique innovation to this model. Moreover, starting in Year 3, D-ACOs will also face some risk of loss in the event that their aligned beneficiaries' total cost of care exceeds targets, though, as described below; that risk will be buffered against the consequences of so-called catastrophic cost outcomes that are beyond the control of those on the front lines.



#### a. Compensation for Care Coordination

D-ACOs will receive a care management fee per beneficiary per month (PBPM) from DHMH to apply toward costs of care coordination and case management. This up-front fee is intended to ensure the availability of intensive care management and coordination services without regard to the timing or amount of shared savings. D-ACOs will be expected to show how the funding will be applied to care coordination and care management; they will not be allowed to divert the funding to other uses.

D-ACOs will be expected to flow a portion of the care coordination payment down to participating PCHHs, but the determination of how much of the fee is distributed to any one PCHH will be left up to the D-ACO's discretion, based on the level of care coordination functions the PCHH is equipped to handle. This will allow the D-ACO the flexibility to partner with a network of PCHH entities having a broader range of financial resources and in-house care management capacity.

The PBPM payment will be tiered based on beneficiary risk stratification (driven by physical, behavioral, LTSS and social needs) as indicated by historical utilization data for population cohorts, not individuals. The payment to individual organizations may be adjusted where they are already receiving care coordination payments from different programs.

DHMH estimates that the PBPM will equal no more than 2 percent of the TCOC. Applying this percentage to the CY 2012 cost base, the average across all Medicare-Medicaid dual eligible beneficiaries would be approximately \$64 PBPM. Amounts in individual risk tiers may be proportional to the per capita health costs per tier, but it is conceivable the amounts would be weighted differently to take account of other pertinent factors such as the availability of other resources to support care coordination for some groups of beneficiaries.

The payment of the PBPM fee will begin the first month following the D-ACO's successful submission of an encounter file to DHMH documenting the completion of an initial care plan. The PBPM will continue flowing for as long as the beneficiary is designated to the D-ACO and the care plan continues to be managed and updated according to the care management policy requirements. No additional monthly encounter submissions will be necessary.

In addition, there will be a one-time payment of an enhanced fee for the completion of the initial care plan to compensate for higher outreach, engagement, assessment, and care planning costs. This initial care planning payment will be equal to 2 or 3 months' worth of ongoing PBPM payment (it will also vary by risk tier) and will be made upon the submission of a successful encounter to DHMH for the complete initial care plan.

Care coordination funds will be sourced from CMS, as allocated out of anticipated health cost savings from the model. Additionally, CMS would move its normally-claimable Medicare CCM fees for designated Medicare-Medicaid dual eligible beneficiaries to this care coordination fund.<sup>5</sup>

This innovative care management fee will enable D-ACOs to perform outreach, engagement, and care planning to adequately onboard dual-eligible beneficiaries into an effective care management program. In contrast to MSSP, D-ACOs will not have to rely entirely on the hope of shared savings, which, even if realized, will occur more than 18 months after the initiation of care management.

#### **b. Rewards and Risks to Promote Value in D-ACOs**

D-ACOs will also be subject to a reward and risk model having some similarities to the MSSP ACO program. This reward/risk overlay to the care management fee mechanism will ensure that D-ACOs have a strong incentive to make the care management process work effectively.

As noted, all provider payment for care will consist of regular Medicare/Medicaid fee-for-service. A total cost of care target will be established for each D-ACO's designated beneficiary population for the purpose of calculating savings or losses. This target will encompass all Medicaid spending as well as all Medicare parts A and B spending for affected beneficiaries.

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<sup>5</sup> Chronic Care Management: "At least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month." CMS code 99490 – paid at \$42/month.

Outpatient prescription drug expenditures under Medicare Part D will be excluded from the TCOC calculation and the calculation of any shared savings or losses because they are subject to a capitated rate setting process that sits outside the fee-for-service system. Nevertheless, D-ACOs are still required to incorporate outpatient prescription drug therapies in the care planning and care coordination process including medication adherence and reconciliation.

### 1. Cost of Care Targets

Upon a beneficiary's designation to a D-ACO, DHMH will credit a total cost of care projection per beneficiary per month to a pool associated with that entity. At end of the performance year, the actual TCOC will be calculated and compared to the TCOC target.

The TCOC target is expected to be a blended PBPM amount for each D-ACO, which will need to consider adjustments for the following:

- i. **Population Mix:** Subsets of the dual eligible beneficiary population, with unique differences in risk, include: (a) Long Term Nursing Facility Residents, (b) HCBS Recipients – sub-segmented by highest need and over and under age 65, (c) Community Dwelling, and (d) Individuals with Certain Mental Health Diagnoses. Given the wide variation of risk for each of these subpopulations, the proportion of each subpopulation that makes up the total D-ACO enrolled population will need to be considered when creating the specific D-ACO blended benchmark. Given that the identification of these particular subgroups requires a retrospective claims-level analysis, the actual subgroups will not be known at the beginning of the year; as a result, some level of historical mix of these subpopulations, in addition to emerging experience that reflects the actual enrollment mix of a particular D-ACO, will be implemented to make this adjustment.
- ii. **Risk Adjustment:** DHMH does not at this time intend to risk adjust on an individual beneficiary level, such as is done with capitation rates for Medicare Advantage plans. Instead, each beneficiary will be identified with a cohort, as indicated above. However, through the development period, DHMH will investigate the feasibility of a functional ability risk adjuster that would reflect not strictly health status but rather the individual's capacity to engage in health-related behaviors. Such functional ability scores may consider beneficiary capacity to perform commonly recognized activities of daily living and may also consider social factors such as homelessness. Two mechanisms that are already in place in Maryland that could be considered in the model, are the RUGS and interRAI tools, which are used to evaluate nursing facility and HCBS resource needs, respectively. These are mechanisms that may be used to adjust the TCOC benchmark to reflect the level of resource need for LTSS services.

- iii. **Reimbursement Differences:** Differences in reimbursement for key services will be factored into the blended benchmark, particularly for Nursing Facility and Inpatient Hospital services. As the underlying reimbursement level for these providers may vary significantly between providers in one D-ACO or another, adjustments will be necessary to account for variation that is not due to care management, but instead due to provider contracting differences.

## **2. Rewards and Risks**

Initially, D-ACOs will have the opportunity to earn rewards for producing both savings and meeting quality targets, but they will not be at risk for net deficits. Beginning in Year 3, downside risk will be added; however, at all times, the D-ACO reward/risk formula will be skewed more toward incentive bonus than to penalty. A tiered savings/loss methodology will be used to determine how the resulting savings or losses would be distributed between the State and D-ACOs. These tiers will be set up such that the D-ACO will assume increasing responsibility with greater savings or losses, subject to the shareable losses/savings cap.

A D-ACO will be deemed eligible for an award if the savings and quality thresholds are reached. Failure to reach the minimum quality score or an expenditure deficit will result in a reduced award or the loss of the award. The figure below presents a conceptual illustration of the reward/risk formula.

A D-ACO will be obligated to distribute a meaningful portion of any award, or loss share, to participating providers – of all types – that contributed to the result. This would allow Medicare providers to potentially benefit from Medicaid savings and vice versa under the theory that providers in one program may have an impact on the outcome of health for the other.

A D-ACO may retain some of any award to offset operational expenses not otherwise covered by the retained care coordination fee, to build a reserve to cover future loss shares owed, or for other purposes of its choosing.

Each D-ACO's shared savings distribution methodology will be subject to DHMH prior approval, must be included in the participation agreements between participating providers and the D-ACO, and must include provisions conditioning the distribution of savings based on the quality and level of per-patient contributions to the overall D-ACO performance. Precise formulas are still to be determined, with a key objective being to make sure that PCHHs will qualify as advanced alternative payment models under MACRA's Quality Payment Program.

		Losses (Yr. 3 & After)			Savings		
Actual Spend vs. Target:		> 5%	2 - 5%	0 - 2%	0 - 2%	2 - 5%	> 5%
D-ACO Quality Rating	Highest	20%	10%	0%	40%	50%	60%
	High	30%	20%	10%	30%	40%	50%
	Acceptable	40%	30%	20%	20%	30%	40%
	Less Than Acceptable	50%	40%	30%	0%	0%	0%

In years 1-2, a D-ACO has no downside risk; its share of any loss = 0%

Quality rating must be at least Acceptable for D-ACO to earn any savings award

To protect D-ACOs against the possibility that individual high-cost cases will lead to aggregate losses or deplete otherwise deserved savings, the model will include a specific stop-loss feature. The most costly cases will be removed from performance calculations, as well as from the computation of the baseline TCOC target. The resulting dollar threshold, as derived from the predetermined percentile, may be separately calculated for different subpopulations, to account for differences in spend for certain services, such as LTSS.

In addition, once D-ACO downside risk begins in Year 3, there will be an aggregate stop-loss protection feature. Any D-ACO owing back money in the form of a loss share will not have to pay an amount more than 5 percent of the TCOC target. For balance, the same 5 percent limit will apply to savings awards payable to D-ACOs.

### VIII. Quality Measurement

As noted above, quality will be an important factor in the incentive formula. Rewards paid out for generating savings will increase to the extent that quality performance also rises. Based on technical reporting requirements that DHMH will develop with input from CMS and stakeholders, DHMH will calculate quarterly and annual performance reports involving submissions of data from D-ACOs when necessary.

Furthermore, DHMH will regularly analyze process and outcome measures to assess for programmatic improvements and areas of deficiency, and to ensure the incentives do not inadvertently promote unintended results: reduced health outcomes or poor beneficiary



experience. D-ACOs will be required to conduct similar analyses of metrics related to quality of care, process, and outcome reporting for their PCHHs. Finally, the quality measures used for the shared savings calculation will also be used by the independent evaluator to assess the effectiveness of the model.

#### **a. Quality Measure Selection Framework**

DHMH has identified an introductory quality measure set for the D-ACO program based on clearly-defined goals.<sup>6</sup> DHMH sought to ensure that beneficiaries are protected from harm, that cost savings are associated with improved quality of care and quality of life, and to create alignment of measures across elements of the All-Payer Model and other payment initiatives including the MACRA Quality Payment Program.

DHMH also sought to ensure coverage of key domains of care for Medicare-Medicaid dual eligible beneficiaries, to utilize measures that assess quality of life, to rely upon validated measures from credible stewards, to focus any process measures on care coordination, and to minimize the total measures to reduce reporting burden. Building from this base, DHMH has the flexibility to expand and include disease specific metrics and duals' population cohort metrics.

The introductory set does not feature metrics focused on LTSS and community integration, though the DHMH will incorporate those metrics into the measure set as the D-ACO program is designed further. Other measures that may arise as the All-Payer Model progresses can be incorporated as well.

Finally, for consistency with MACRA provisions, DHMH is considering establishing some of the measures as improvement measures where appropriate and requiring continuous quality improvement.

#### **b. Measure Performance Assessment Methodology**

The quality measure performance assessment methodology for the D-ACO program builds upon the approach used in the MSSP ACO model and seeks to both recognize a greater continuum of quality and create incentives for ongoing quality improvement. In particular, as indicated in the shared savings/losses table above, D-ACO quality performance will be calculated and scored into: "less than acceptable," "acceptable," "high," and "highest."

Each D-ACO will have its performance on each measure rated based on either a clustering approach or a relative distribution and significance approach depending on the type of measure in a manner roughly akin to the Star Ratings cut points system for Medicare Advantage. This will ensure that what constitutes "less than acceptable," "acceptable," "high," or "highest" for a

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<sup>6</sup> See the Appendix for the list of core quality measures proposed for the D-ACO program.

given measure is very similar for each D-ACO. Summary ratings for each D-ACO will then be calculated by using a weighted average of the measure-level ratings.

DHMH will determine the weighting of each measure in partnership with CMS once the final measure set has been established but the final weighting methodology will prioritize improvement and outcome measures over process measures. The final D-ACO summary rating will then be used to determine the D-ACO's eligibility to receive a level of shared savings/losses as described above.

## **IX. Demonstration and Program Authority**

### **a. Demonstration Authority**

Under the authority at Section 1115A of the Social Security Act ("Act"), the Center for Medicare and Medicaid Innovation is authorized to "...test payment and service delivery models ...to determine the effect of applying such models under [Medicare and Medicaid]." Such models include but are not limited to the models described in section 1115A(b)(2)(B) of the Act including the D-ACO program. Section 1115A(d)(1) authorizes the Secretary to waive such requirements of titles XI and XVIII of the Act and of Sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) of the Act as may be necessary solely for purposes of testing models described in section 1115A(b).

### **b. Medicare Authority**

The Medicare portions of the D-ACO program will operate according to existing Medicare law, regulation, and sub-regulatory guidance, and will be subject to existing requirements for financial and program integrity, except to the extent these requirements are waived or modified. Such waivers are likely to include the same fraud and abuse waivers created to support the MSSP ACO program, including: the Pre-Participation Waiver, Participation Waiver, Shared Savings Waiver, Compliance with Stark Law Waiver, and the Patient Incentive Waiver. For D-ACO participants to successfully and confidently engage in care management, without fear of fraud and abuse liability, they may need some protection from the fraud and abuse laws that would constrain their activities in the fee-for-service system. The Pre-Participation Waiver will allow D-ACO participants to fund development for the benefit of the participating providers without the risk of liability under certain federal fraud and abuse laws, including Stark Law, anti-kickback statutes, gainsharing, and beneficiary inducement civil monetary penalties.

The Participation Waiver can allow a D-ACO participant to undertake certain actions for the D-ACO during operations itself that might otherwise implicate the federal fraud and abuse laws. The Shared Savings Waiver will be crucial to allow for shared savings received by the D-ACO to be applied in compliance with the distribution methodology policies DHMH will promulgate. The Compliance with Stark Law Waiver will protect arrangements meeting a Stark Law exception from liability under the anti-kickback laws or gainsharing civil monetary penalties.

Finally, the Patient Incentive Waiver allows a D-ACO to offer to its designated beneficiaries certain non-monetary preventive items or services which may be included in the plan of care. Additional waivers may be necessary to provide for alterations to the CCM fee claiming for D-ACO designees and for the sharing of Medicare savings/losses to D-ACOs. Following further refinement of the D-ACO program design, DHMH will engage with CMMI, Center for Medicare, and CMS Office of General Counsel (OGC) on any other necessary Medicare waivers.

**c. Medicaid Authority**

The Medicaid elements of the D-ACO program will operate according to existing federal and state Medicaid law and regulation, sub-regulatory guidance, and existing requirements for financial and program integrity, except to the extent these requirements are waived specifically for this program. Maryland will submit State Plan Amendments (SPAs) or waivers for Medicaid services and implementation of the D-ACO program as necessary following discussion with CMS. Approval of D-ACO participation agreements will be contingent upon CMS approval of any necessary SPAs or waivers. Waiver authority will likely be necessary to enable the additional care management services, to allow them to be made available on a regional basis rather than statewide, and to provide for the sharing of Medicaid savings/losses.

**X. Coordination with Other Models**

To the extent that D-ACOs envisioned to serve the Medicare-Medicaid dual eligible population can perform duties on behalf of other populations under other agreements, they will be free to do so. For instance, DHMH envisions that many of the D-ACO entities will already be entities participating in the MSSP ACO program. PCHHs inside D-ACOs likely will also perform similar functions for non-dual-eligibles under other programs. Role definitions and terms of trade will be specified jointly and will be made consistent wherever feasible. The assignment of care coordination responsibilities will be unified so that, as much as possible, each individual will have a single care coordinator acting on her/his behalf across all settings of care at all times.

Where established rules call for setting-specific care coordinators that cannot legally be eliminated, the central care coordinator will work to ensure the beneficiary experiences neither conflicting support nor gaps in support.

**a. All-Payer Model**

DHMH and the Maryland Health Services Cost Review Commission (HSCRC) have collaborated throughout the planning of this D-ACO program to ensure that this initiative and any new features of the All-Payer Model that emerge in 2019 will operate in complementary and harmonious fashion, without duplication or conflict.

Functionally, for Medicare-Medicaid dual-eligible beneficiaries designated to a D-ACO, the D-ACO will have primary responsibility for care management. Any providers or entities, such as hospitals participating in the HSCRC Complex and Chronic Care Improvement Project (CCIP) or

Hospital Care Improvement Project (HCIP) tasked with providing post-acute care transitions or other care coordination services will complement the D-ACO and PCHH care coordination and care-management teams.

Financially, the D-ACO model will complement and leverage the global budget revenue (GBR) arrangement that governs how Maryland hospitals are paid. It will widen the group of actors that are motivated to reduce utilization. Moreover, the model will inspire participants to contain usage of the full array of Medicaid- and Medicare-covered services.

The D-ACO program will be treated as a virtual payer. Medicaid and Medicare will both continue to pay claims using the established all-payer rates. However, from an accounting standpoint, the D-ACO program ledger would be credited with an income stream equal to the TCOC projection for the whole population. That same ledger would be debited with claims costs as incurred. At the end of each year there would be a tally of the collective income and outlays of all D-ACOs to determine if there are savings or losses. That will be followed by a reconciliation process, with awards of savings shares to those D-ACOs that generated savings and collection of any loss shares owed by those that produced overruns, as described earlier.

#### **b. Maryland Comprehensive Primary Care Model**

As noted at the beginning of this paper, the DHMH is working with CMMI to design the Maryland Comprehensive Primary Care Model, a statewide primary care transformation vision. The aim is to create advanced Person Centered Homes that are intended to serve Medicare beneficiaries – including dual eligibles – and others residing outside the D-ACO regions. Within the D-ACO regions, many of these primary care homes could participate in D-ACOs as PCHHs.

### **XI. State Share of Federal Savings**

DHMH expects to negotiate a savings arrangement with CMS whereby the State of Maryland will be eligible to receive one-half of remaining federal government savings on both Medicaid and Medicare spending for Medicare-Medicaid dual-eligible beneficiaries served by D-ACOs.

Savings calculations would be made using the TCOC targets and factoring in both claims/benefits expenditures and outlays made for care coordination functions. Savings available for sharing by the State would be net of any bonus payments made to D-ACOs pursuant to their incentive formulas.

**APPENDIX: CORE QUALITY MEASURES FOR DUAL ELIGIBLES ACO**

<b>Measures</b>	<b>Data Source</b>	<b>Focus</b>	<b>NQF #/Measure Steward</b>
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Claims/ E H R	B, M	4/NCQA
CAHPS Health Plan v 4.0 - Adult questionnaire	Beneficiary Reports	M	6/AHRQ
Controlling High Blood Pressure	Under Reconsideration NQF	O, C, M	18/NCQA
Preventive Care and Screening: Tobacco Use: Screening & Cessation Intervention	Claims/E H R /Paper or Registry	C, S, M	28/AMA Consortium
Medication Reconciliation - Post Discharge	Claims/E H R /Paper or Registry	C, S, M	97/NCQA
Falls: Screening, risk-Assessment, and Plan of Care to Prevent Future Falls	Claims/E H R /Paper	M	101/NCQA, AMA Consortium
3-Item Care Transition Measure at Hospital Discharge (Needs, responsibility and medications)	Beneficiary Reported Data	S	228/University of Colorado
Advanced Care Plan	Claims/E H R	S, M	326/NCQA, AMA Consortium
Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Claims/Paper/Other	B, M	418/CMS, Mathematica, Quality Institute of PA
Documentation of Current Medications in Medical Record	Claims/Other/Registry	S, M	419/CMS, Mathematica, Quality Institute of PA (QIPA)
Adult Weight Screening and Follow-up	Claims/Other/Paper/Registry	C, M	421/CMS, Mathematica, QIPA
Follow-Up After Hospitalization for Mental Illness	Claims/E H R	B, M	576/NCQA
Timely Transmission of Transition record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	Claims/Other/Paper	\$	648/AMA Consortium
Plan All-Cause Readmissions	Claims	\$	1768/NCQA
Antipsychotic use in persons with dementia (New Measure)	Claims	B	2111/Pharmacy Quality Alliance
Sepsis - Appropriate treatment of MSSA (Methicillin-sensitive Staphylococcus aureus) Bacteremia (Note sepsis measures are undergoing revision.	Claims/E H R	M	CMS 407/Infectious Disease Society of America

Legend: B= Behavioral; O = Outcomes; C = Consensus Core Set; S = Shared Savings Program; \$ = Efficiency Coordination Opportunity; M = MACRA – For a list of MACRA Quality measures see Federal Register, Volume 81, No 89, May 9, 2016; pages 28399 – 28586.